Student's name: _____

ACADEMIC RECOMMENDATION FORM GUIDELINES

The Global Undergraduate Exchange Program (Global UGRAD) provides scholarships for talented students from around the world to attend U.S. universities and colleges for one semester of undergraduate, non-degree study. The Global UGRAD program, sponsored by the U.S. Department of State's Bureau of Educational and Cultural Affairs, is supported by the people of the United States. The program is administered through the joint efforts of the U.S. Department of State's Bureau of Educational and Cultural Affairs, the U.S. Embassies, and World Learning.

To be completed by a University Professor familiar with the student's work in his or her major field of study. Recommendations should not be from family members or friends.

Instructions: *Your statement will be given considerable importance by the American universities and colleges reviewing the student's application, and therefore should be as complete and detailed as possible. Please, include your candid evaluation of the student's ability to participate in such an exchange program by indicating:*

a) in what context you know the student;
b) how you would describe the mentality and adaptability of the student in difficult situations;
c) the qualities that would make the student a successful exchange student including their interaction with others.

This recommendation should be typewritten or clearly printed in English, if possible. If not in English, an accurate translation must be attached. ***You do not have to use this form for your recommendation but please include all of the information below if you do not submit your recommendation on this form.***

Recommended by:
Place of Employment:
Address:
Telephone:
Signature:
Date:

Student's name: _____

SECOND RECOMMENDATION FORM GUIDELINES

The Global Undergraduate Exchange Program (Global UGRAD) provides scholarships for talented students from around the world to attend U.S. universities and colleges for one semester of undergraduate, non-degree study. The Global UGRAD program, sponsored by the U.S. Department of State's Bureau of Educational and Cultural Affairs, is supported by the people of the United States. The program is administered through the joint efforts of the U.S. Department of State's Bureau of Educational and Cultural Affairs, the U.S. Embassies, and World Learning.

To be completed by a Professor familiar with the student's work in his or her major field of study, OR from an employer, former exchange program coordinator or host family, coach, or any supervisor or authority familiar with the student's extra curricular activities. Recommendations should not be from family members or friends.

Instructions: *Your statement will be given considerable importance by the American universities and colleges reviewing the student's application, and therefore should be as complete and detailed as possible. Please, include your candid evaluation of the student's ability to participate in such an exchange program by indicating:*

d) in what context you know the student;
e) how you would describe the mentality and adaptability of the student in difficult situations;
f) the qualities that would make the student a successful exchange student including their interaction with others.

This recommendation should be typewritten or clearly printed in English, if possible. If not in English, an accurate translation must be attached. ***You do not have to use this form for your recommendation but please include all of the information below if you do not submit your recommendation on this form.***

Recommended by:
Place of Employment:
Address:
Telephone:
Signature:
Date:

Department of State Academic Exchanges
Participant Medical History and Examination Form

Having been selected to participate in a U.S. Department of State educational exchange program, you are required to submit a completed Medical History and Examination Form. The attached form should be completed and returned to:

Participants will complete **Parts I, II and III** prior to the medical examination. **Parts V, VI and VII** must be completed by a qualified, licensed doctor, physician or nurse practitioner no more than twelve (12) months before your grant start date.

The purpose of these forms is to confirm health status for review and medical clearance, upon which a grant is contingent. The information will also help your program staff be of maximum assistance to you should the need arise while you are on a grant. Mild physical or psychological disorders can become serious under the stresses of life in an unfamiliar environment. It is important that we be made aware of any medical, emotional or psychological problems, past or current, which might affect you while on your program.

The Medical History and Examination Form should be completed in English by a licensed physician, doctor (MD, DO, or foreign equivalent), or nurse practitioner who is not a member of your family and mailed to your program staff before your participation in the program can be confirmed. Violation of this policy may result in termination or revocation of your grant. If the forms are completed by a health practitioner who is not an MD, DO, or nurse practitioner, it must be cosigned by an MD or DO. Your award is contingent upon your submitting the Medical History and Examination Form to your program staff by stated deadlines, and remains contingent until the information is reviewed and satisfactory medical clearance is issued.

INSTRUCTIONS TO PROSPECTIVE PARTICIPANTS

In advance of your medical examination:

- Complete **Parts I, II and III** on your own prior to the physical examination.
- Familiarize yourself with the instructions to the physician.
- Understand the scope of the clinical examination and the tests required for your age and/or known condition so that you can be sure that the requirements of the form will be met.

At the time of your medical examination*:*

- Sign and date the form on page 9.
- Assure that your health is evaluated in **Parts II and III** and that the form is signed by a physician. (Although physicians' offices sometimes use a physician's assistant or R.N. to help perform the examination and tests, only a physician or a nurse practitioner may sign the form.)
- Ask your physician to mail the completed report and test results to you as soon as possible.
- Check the form to make sure that **Parts V, VI and VII** have been completed. If the form is incomplete or if the results of the required tests are not reported, your program staff will return the form to you. This step costs time and may require a return visit to the physician. Please prevent such delays.

Following the medical examination:

- Make a copy of the completed **Medical History and Examination Form** for your files.
- Mail the **ORIGINAL** completed **Medical History and Examination Form** to IIE at the address listed at the top of this page.

PART I: PARTICIPANT BACKGROUND AND CONTACT INFORMATION: *To be Completed by Participant*

Please type or print in ink.

NAME: _____ *Last* *First* *Other*	
DATE OF BIRTH: _____ *Month/Day/Year*	SEX: ❍ Male ❍ Female
PRESENT ADDRESS: *Home or Residence* *City* *Country*	
If known, provide Grant Location – City and Country: Briefly describe (e.g., urban, rural, climate, etc.)	
GRANT DATES (approximate if unknown): From : To:	

Will you be covered by private health insurance while on your program? ❍ **Yes** ❍ **No**
If yes, complete the following information. In addition, please confirm with your provider that your coverage extends to your time overseas for your award. Be aware that your existing coverage will remain your primary insurance for the duration of your grant.

Name of Health Plan/Health Care Provider:	
Health Plan ID #:	
Health Plan Effective Date:	
Health Care Provider Address:	

Please provide names of medical professionals consulted within the last 3 years, except for routine physical examinations. List your primary care physician as well as any specialists. *(Submit an additional form as needed).*

NAME	SPECIALTY or Primary Care	TELEPHONE #
	Primary Care Physician	

EMERGENCY CONTACT INFORMATION AND MEDICAL PROXY: *To be Completed by Participant*

Identify two individuals to notify in case of emergency.

PRIMARY EMERGENCY CONTACT:	**SECONDARY EMERGENCY CONTACT:**
Name:	Name:
Address:	Address:
Cell phone number:	Cell phone number:
Home number:	Home number:
Office number:	Office number:
Email:	Email:

While your academic exchange program does not require that you have established a medical proxy (a medical proxy is an individual who is informed of and can make decisions about your medical wishes on your behalf if you are unable), it is strongly recommended that you consider this option for any emergency medical situations that may result while you are abroad. Should you already have a designated medical proxy, please indicate them below and provide a copy of the documentation along with your medical examination results.

If you have a legal medical proxy, indicate them below and provide a copy of the supporting documentation. (Most U.S. states have forms for the purpose of designating a medical proxy):

MEDICAL PROXY CONTACT (*Optional*):
Name:
Address:
Cell phone number:
Home number:
Office number:
Email:

PART II: PARTICIPANT MEDICAL HISTORY: *To be Completed by Participant*

To be completed by the participant prior to the Medical Examination.

Have you ever been diagnosed with/treated for any of the following conditions? Please indicate by answering YES or NO. **YES answers must be explained in the space below, indicating dates, nature of diagnosis and treatment, as well as the current status. Attach additional pages if necessary.** Further explanation may be required in **Part V** which is completed by the physician conducting the Medical Examination.

For any items checked "Yes," the physician may recommend a test to allow for further explanation of the current status of the condition and/or the prognosis or outcome.

MEDICAL HISTORY					
CHECK EACH ITEM	**YES**	**NO**		**YES**	**NO**
Frequent or severe headaches			Fainting spells (syncope)		
Epilepsy or seizures			Heart condition incl. arrhythmia, angina, heart attack, murmur, and heart failure		
Stroke			Eye disease or vision impairment (other than corrected refractive error)		
Hearing impairment			Severe allergies, including environmental, insect stings, food, and medication		
Tooth or gum disease (periodontal disease)			Tropical diseases, incl. malaria, amoebiasis, leprosy, filariasis, etc.).		
Asthma, emphysema, persistent cough, or other lung conditions.			Severe skin disorder		
Tuberculosis			HIV infection, AIDS		
High blood pressure pressure			Cancer in any form		
Gynecological disorder			Depression, anxiety, excessive worry, or related		
Other hormonal disorders, incl. thyroid			Schizophrenia, psychosis, bi-polar disorder, or related		
Diabetes mellitus (high blood sugar, sugar in urine)			Anorexia, bulimia, obsessive-compulsive disorder or related		
Sickle cell anemia, excessive bleeding, blood clots or other blood disorder			Drug or alcohol abuse		

In addition to explaining any items above to which you answered YES, have you experienced any other health conditions (physical or psychological) in the last five years which could impact you while living overseas? If yes, please explain. Attach additional pages if necessary.

PART III: VACCINATION HISTORY: *To be Completed by the Participant*

NOTE: IT IS THE PARTICIPANT'S RESPONSIBILITY TO DETERMINE ANY TEST SPECIFICALLY REQUIRED BY HIS/HER HOST COUNTRY.

Below are the generally recommended vaccinations for foreign participants traveling to the United States only. **Participant and physician should discuss relevance of vaccinations related to the participant's grant location.**

Approximate dates of immunizations if unknown.

POLIO (Three or more doses)	**Dates of immunization:**
DIPHTHERIA, PERTUSSIS, TETANUS (Three or more doses,one within the past 10 years)	**Dates of immunization:**
MEASLES – MUMPS – RUBELLA (MMR) (Or list individual Measles, Mumps, and Rubella immunizations below)	**Date of immunization:**
MEASLES **Dates of Live Immunization** (two required, at least one month apart) **(or) Indicate date of disease** **(or) Indicate date and results of measles titer**	**First immunization date:** **Second immunization date:** **(or) Date of Disease:** **(or) Date and result of measles titer:**
MUMPS **Dates of Immunization** (two required, at least one month apart) **(or) Indicate date of disease** **(or) Indicate date and results of mumps titer**	**First immunization date:** **Second immunization date:** **(or) Date of Disease:** **(or) Date and result of mumps titer:**
RUBELLA Dates of Immunization (two required, at least one month apart) **(or) Indicate date and results of rubella titer** ***Note**: History of disease is not acceptable proof of immunity to rubella*	**First immunization date:** **Second immunization date:** **(or) Date and result of rubella titer:**

PART IV: INSTRUCTIONS FOR THE EXAMINING PHYSICIAN

The individual you are examining is a participant for an educational exchange program who will reside in another country. Some locations are remote and may have limited medical support from doctors, nurses, laboratory facilities and hospitals.

Please evaluate thoroughly all items listed in the PARTICIPANT MEDICAL HISTORY. It is most important that you:

- Discuss medical history with the participant, conduct a general medical examination, and respond to the questions on pages 6, 7 and 8.
- If the space is not sufficient for a thorough explanation, feel free to attach additional pages.
- Enter N/A in the space if the question is not applicable to the participant.
- There are **no specific laboratory tests required,** although the exchange program may request further testing based on the participant's medical history. Physicians are encouraged to obtain appropriate tests as indicated by the medical history and results of the physical examination or place of grant activity. For example, G6PD for participants in malarial areas, recent blood sugar determination for diabetic patients or CD4 counts for patients with HIV infection.
- Order and record (or attach copies of) all relevant laboratory tests or necessary data. If there are test results within the past twelve months, please also attach.
- After completing the medical examination, record all findings on pages 6, 7 and 8. *Only the results of a physical exam performed no more than twelve (12) months prior to the grant start date may be reported.*
- Comment on all indicated follow-up examinations and conditions that may require frequent observation or prolonged treatment. Please indicate your overall opinion of the examinee's health on page 8.
- Sign and date page 8.

PART V: MEDICAL EXAMINATION HISTORY: *To Be Completed by Physician*

1. If the participant answered "YES" to any of the conditions listed in the medical history in Part II, please discuss with participant and comment below. Include dates of occurrence, treatment and outcome, if not indicated in the participant's explanation, and if and how the condition may impact participation in the program abroad.

2. Has the participant ever had any significant or serious illness or injury not mentioned in the medical history? If so, explain the nature of the problem and outcome.

3. Please explain any operations (surgical procedures) the participant has had that may impact the participant's experience on the program.

4. Has the participant ever been hospitalized for any reason? If so, list the condition(s), provide dates of treatment, and explain the outcome.

5. Has the participant ever seen a psychiatrist, psychologist, or psychotherapist? If so, list the condition(s), provide dates of treatment and explain the outcome.

PART VI. MEDICAL EXAMINATION REPORT: *To be Completed by Physician*

THIS PHYSICAL EXAMINATION REPORT MUST BE COMPLETED IN ENGLISH BY A DESIGNATED AND QUALIFIED DOCTOR, PHYSICIAN OR NURSE PRACTITIONER AFTER REVIEWING THE EXAMINEE'S MEDICAL HISTORY (PART II), CONDUCTING A PHYSICAL EXAMINATION, AND ASSESSING LABORATORY AND X-RAY RESULTS. THE EXAMINING PHYSICIAN MUST COMMENT ON ALL POSITIVE AND/OR SIGNIFICANT FINDINGS IN THE SPACE PROVIDED.

Note: Results of tests and X-rays included in this medical evaluation must be no more than twelve (12) months prior to the date of the participant's departure from the United States.

Please type or print in ink

EXAMINEE'S NAME: _____

Last *First* *Other*

HEIGHT: *(in or cm)* _____ W**EIGHT**: *(lb or kg)*

BLOOD PRESSURE: *Syst./diast.* _____ **RESTING HEART RATE**:

CLINICAL EVALUATION Please provide an answer to each item.			
	NORMAL	ABNORMAL	DESCRIBE ABNORMAL FINDINGS
Head and neck			
Hearing Acuity			
Visual Acuity (with corrective lenses, if used)			
Lungs and chest			
Heart and vascular system			
Abdomen			
Breasts			
Genito-urinary/Gynecologic			
Musculoskeletal			
Lymphatic			
Neurologic			
Skin			
Psychiatric			

1. List all the medications taken by the participant in the past three (3) years.

2. List all specific medications (generic or name brand) currently being taken by the participant, whether on a regular or as needed basis.

3. List all medical devices being used by the participant (for example: insulin pump, prostheses, nebulizers).

4. Results of laboratory tests may be reported below. Indicate type of and reason for test and the results. Attach additional information or documentation where appropriate.

PART VII: PHYSICIAN'S STATEMENT: *To be Completed by Physician*

Based on your physical examination and on the participant's physical and emotional history, do you consider the examinee physically and emotionally able to study, teach or conduct research in the country indicated on page 2 of the form?

❒Yes ❒Conditional

Please take into account the country, location and nature of the grant activity.

If Conditional, please explain:

Signature of Examining/Supervising Physician:_____ **Date:**_____

Name of Examining/Supervising Physician:_____

Telephone #:_____ **Email address:**_____

Address_____

A test for TB is required for foreign participants traveling to the United States only at the time of examination, regardless of prior BCG vaccination. The PPD skin test or interferon gamma release assay blood test is acceptable. PPD skin test results over 10mm require a chest X-ray. An abnormal result on either test mandates a chest X-ray to evaluate for active tuberculosis.

Tuberculin Skin Test (PPD) Result (millimeters of induration):
_____ ☐ **Pos** ☐ **Neg**

Date of test: _____
OR
IGRA Test Date: _____ ☐ **Pos** ☐ **Neg**

Chest X-ray (if required) Date: _____

Chest X-ray findings:
(Note to Physician: X-ray images need not be submitted on film or otherwise.)

PART VIII: PARTICIPANT'S STATEMENT: *To be Completed by Participant*

I certify that I have reviewed the information entered in **Parts I, II and III**, and have discussed subsequently with a doctor, physician or nurse practitioner the information in **Parts V, VI and VII**. I have discussed with my examining physician the need for any additional tests or the need for immunizations, antimalarial drugs, or other prophylaxis based on the region where I will reside abroad. This information is true and complete to the best of my knowledge. I am aware that the information in this form and any attachments (i.e., laboratory tests, X-rays, etc.) are being provided to the administrating agency abroad as part of the medical clearance process.

I acknowledge that falsifying or knowingly excluding critical medical information may jeopardize my participation in this educational exchange program. Furthermore, I understand that if any of this information is found to be substantially inaccurate or incomplete, it may result in termination of my grant and result in my return home.

Prior to departure, or during the grant program, I understand that I must immediately notify the Institute of International Education of any changes in my medical status or overall health and wellness. During the grant program, I must immediately notify the Post or Fulbright Commission, as well as IIE, of any change in my medical status.

In the event of a medical emergency or serious illness during the grant program, I authorize release of my medical information and records to the U.S. Department of State or its designated contractual agency.

Signature: _____ **Date**: _____

The information provided by you and your physician(s) is considered private. However, it will be responsibly shared within organizations administrating your host country affiliation and/or grant program.


DEPARTMENT OF STATE
UNITED STATES OF AMERICA


World Learning
Education | Development | Exchange